

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011167

STATE FILE NUMBER

2265

FILED MAR 17 1959

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN ST. LOUIS

Inside Limits
Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE MISSOURI b. COUNTY

c. CITY
OR
TOWN ST. LOUIS

Inside Limits
Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb
HOSPITAL OR ST. LOUIS CITY HOSPITAL # 1.
INSTITUTION

d. STREET ADDRESS 1228 N 9th St

Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Charles

Mc Manus

4. DATE OF DEATH

Month

Day

Year

#3 - 2 - 59

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ 2 DIVORCED ☐

8. DATE OF BIRTH

4-3-81

9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

77

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Switchman

10b. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (City and state or country)

1111015

12. CITIZEN OF WHAT COUNTRY?

USA

13a. FATHER'S NAME

WM Mc Manus

13b. MOTHER'S MAIDEN NAME

Martha Task

14. NAME OF HUSBAND OR WIFE

Alma

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

4200

17. INFORMANT

Myrtle Fleming 10024 Ashbrook

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Myocardial Infarction

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Arteriosclerotic Heart Disease

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT SUICIDE HOMICIDE

☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour Month, Day, Year
a.m.
p.m.

20d. INJURY OCCURRED WHILE AT ☐ NOT WHILE WORK ☐ AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 2-28-59 to 3-2-59 and last saw her alive on 3-2-59
Death occurred at 11:55 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

Arthur A. Smith M.D.

(Degree or title)

22b. ADDRESS

1515 Lafayette Ave.

22c. DATE SIGNED

3-3-59

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

3-5-59

23c. NAME OF CEMETERY OR CREMATORY

City Center

23d. LOCATION (City, town, or county)

Woodson, Ill

(State)

24. FUNERAL DIRECTOR

ADDRESS

Alison 2707 N Grand

25. DATE RECD. BY LOCAL REG.

MAR 5 '59

26. REGISTRAR'S SIGNATURE

Leon Smith M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed

Licensed Embalmer No. 4329

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.